A Spellman

Steeton Court Nursing Home

Inspection report

Steeton Hall Gardens
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Steeton Court is a care home providing personal and nursing care to older people and people living with dementia or physical disabilities. At the time of the inspection there were 38 people using the service which can accommodate up to 68 people in this purpose built two storey home.

People's experience of using this service and what we found
Accidents and incidents were not analysed and not enough was being done to make sure action was taken to minimise risks to people's safety. Medicines management was poor. The security of the home was poor and not enough checks were being completed to make sure the premises were safe. Although staff told us they would report any safeguarding issues we found safeguarding issues had not always been reported to the local authority. The home was clean and odour free.

Staff were not always recruited safely and there were not always enough staff on duty to make sure people received the care and support they needed. Staff training was not up to date and staff did not feel supported in their roles.

Meals at the home were good, however, people's hydration needs were not always being met. The advice from healthcare professionals was not always being followed, which placed people at risk. People said they could see a GP if they needed to.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not always supported to look their best and were not always treated with respect. Care plans lacked detail about people's cultural and spiritual needs and there was little evidence people had been involved in designing their care plans.

Care plans were not person-centred and did not meet people's needs or preferences. End of life care plans only contained very basic information. Complaints had not always been investigated or responded to. Activities and outings were taking place.

Systems in place to monitor, assess and improve the safety and quality of the service being provided were not effective. The safety and oversight of the service was inadequate.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating
The last rating for this service was good (published 8 June 2017) and there were no breaches of regulation.

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, risk management, safeguarding, staffing, staff training, lack of person-centred care, lack of leadership and direction. A decision was made for us to inspect and examine those risks.

We found evidence during this inspection that people were at risk of harm from these concerns. Please see the safe, effective, caring, responsive and well-led sections of this full report.

The provider has sent us an action plan detailing how they intend to mitigate risks to people using the service.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Steeton Court Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, consent, person-centred care, nutrition and hydration, dignity and respect, staff training and support, receiving and acting on complaints, good governance and staff recruitment at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Steeton Court Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector, an assistant inspector, a specialist pharmacy advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Steeton Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was in the early stages of registering with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Both days of this inspection were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with seven people who used the service and five relatives about their experience of the care provided. We spoke with 13 members of staff including the manager, deputy manager, two nurses, two senior care workers, three care workers, one housekeeper, the activities co-ordinator, chef and the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. These included seven people's care records and numerous medication records. We looked at four staff files in relation to recruitment and staff supervision. We looked at a variety of records relating to the management of the service, including policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People's property was not always kept safely. One person told us their relative's hearing aid had been lost. They had recently had this replaced but the new hearing aid had also been lost. Another relative told us, "Two to three months ago we were told that they [staff] had put [Name's] private hearing aids in a safe place because [Name] was losing them. Now nobody can remember where they were put."
- One visitor did not feel their relative was always safe at the home. This was because of an incident with another person who used the service. The provider had taken no additional steps to prevent a reoccurrence. This incident had not been reported to the Local Authority safeguarding team or CQC.
- Staff had received safeguarding training and told us they knew how to recognise and protect people from the risk of abuse. However, concerns and allegations had not always been acted on to make sure people were protected from harm.

This demonstrated a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- Risk assessments had been completed and some measures put in place to try and reduce identified risks. However, not all potential risks had been identified and risk management strategies were inconsistent.
- Some people had been assessed as being at high risk of falling and not enough was being done to manage this risk. For example, monitoring equipment or walking aids were not always being used.
- Security at the home was poor. When inspectors arrived they were let into the building without their identification being checked and given the codes to all the doors.
- The fire risk assessment was out of date which meant we could not be assured of fire safety in the home.
- No checks were being made on window restrictors, bed rails, specialist beds or mattresses to make sure they were safe to be used.
- There was no system in place to ensure accidents and incidents were analysed. This meant measures were not always being taken to prevent a reoccurrence. For example, we were made aware of an accident when an alarm mat had not activated. We looked at the alarm mat and found there were no batteries in it, which was why it was not working. This was brought to the attention of the manager.
- Medicines were not managed safely, and we could not be assured people received medicines safely in line with good practice.
- Medication administration records (MARs) were poorly completed and medicines had not been checked in properly. Stock checks of several items found the amount in stock did not always tally with the

administration records.
● People were supported by the nursing staff with patience and kindness when they were taking their medicines. However, the nurses did not always explain to people what their medicines were for. One person told us, "They give me a tablet and make sure I take it. I don't know what it's for."

This demonstrated a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We asked the provider to take action to remedy the issues in order of most priority.
● A redecoration and refurbishment programme was on-going.

Staffing and recruitment
● Staff were not recruited safely. Staff recruitment files did not evidence all of the necessary checks had been completed. This meant we could not be confident only people suitable to work in the caring profession were employed. We asked the provider to address this.

This demonstrated a breach of Regulation 19 (fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

● There were not always enough suitably qualified, competent, skilled and experienced staff on duty to keep people safe. A number of nurses and care workers had left the service and the manager was trying to recruit new staff. In the interim there was a heavy reliance on the use of agency staff. People who used the service and relatives made the following comments, "It seems short at the moment. You don't see many staff about" and "There are a lot of agency staff who don't know the residents. The new manager has acknowledged that this is a problem and they need more permanent staff."
● The home was divided into four units. There was a lack of leadership and direction on the units which meant people were not always getting safe care and support. One agency worker was allocated to provide one to one support for someone using the service, they sat in an armchair and fell asleep. This was brought to the managers attention and the member of staff was removed from the home.
● Staff told us some people who used the service did not like being cared for by unfamiliar staff.
● Staff told us enough staff were put on the rota to work, however, when people telephoned in sick it was not always possible to get someone to cover their shift, which left them short of staff.
● On the second day of our visit an emergency arose on one of the units when one person became unwell. There were not enough staff to manage the situation safely. We asked the provider to address this.

This demonstrated a breach of Regulation 18 (staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Preventing and controlling infection
● The home was clean and odour free. People's comments included, "It's very clean" and "Yes, they are always cleaning."
● Staff had completed infection control training. People and relatives told us staff wore appropriate protective clothing when assisting people with personal care.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not feel supported and staff morale was low. Staff supervisions were inconsistent or had not taken place. This meant staff were not supported in their role and not able to discuss their ongoing development needs.
- There was no evidence to show agency staff received induction information about the home when they first started working there. One person told us, "I'm nervous with new staff."
- Training records showed there were a large number of staff whose training was out of date. This included training the provider had identified as mandatory for their role.

This demonstrated a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at significant risk of dehydration. The systems in place were ineffective in monitoring people's food and fluid intake.
- Fluid charts did not identify what people's target fluid intake should be each day and what action should be taken if they did not have this. We found examples of people's fluid intake being as low as 800mls in a day.
- People's weights were being monitored, however, the accuracy of the weights was questionable. This meant we could not be assured changes in weight were accurate.
- The chef told us snacks were available for people who needed a liquidised diet. However, people did not always receive these. We asked the provider to ensure people's nutrition and hydration needs were met.

This demonstrated a breach of regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us meals at the home were good. Their comments included, "The food is beautiful I've never eaten so well. You get a choice, but they will make you something different" and "The food is excellent, good quality, service and variety. You get a choice, but the chef will cook something else if you ask. I asked for kippers and they went out and got me some."
- The chef had a good overview of people's preferences and got direct feedback about the meals from people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Advice from health care professionals was not always being followed. For example, a physiotherapist had visited to see one person who was at high risk of falls. The person had been given a walking frame to use. The person did not always have the walking aid with them or when they did were not always using it.

● One person had lost weight and one of the nurses had been asked to contact the GP. There was no evidence this had happened. We asked the provider to ensure advice from health care professionals was being followed.

This demonstrated a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

● People told us their health care needs were met. Their comments included, "The doctor comes regularly; I just ask the staff. They will get me a dentist if I need one," "The doctor comes quickly. I haven't needed to see anybody else" and "The GP comes in once a week and when requested. The staff arranged for the optician to come and the chiropodist calls round regularly."

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● One person had a DoLS authorisation in place which had been granted in June 2019 and had a condition attached to it. The condition required the use of a motion sensor to be reviewed regularly and clearly documented. This had not been done, therefore, the condition had not been met.

● When decisions had been made in people's 'best interest' details of who had been involved in the process had not been documented.

This demonstrated a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It was not always clear how decisions in relation to people's care and lives at the service were decided.

● Some consent documentation had not been completed. This should have been done using the best interest process.

● Checks were not being made to find out if relatives/representatives had the legal authority to make decisions on people's behalf.

This demonstrated a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● Staff spoke with people before any care and support was delivered to get their consent. People told us, "They [staff] are really good. They make sure I'm okay and that I know what they are doing" and "Yes, they talk you through it."

Adapting service, design, decoration to meet people's needs
● The home had been purpose built and the accommodation was spacious.
● Corridors were wide allowing easy wheelchair access.
● Signage was in place to help people find bathrooms and toilets.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The local authority and clinical commissioning group (CCG) stopped people moving into the home in July 2019 because of ongoing concerns.
● The manager told us when the embargo on placements is lifted they would assess people before offering them a place at the home.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect. At breakfast time one person said to a care worker, "I've got no teeth in." The care worker said, "It's okay I've got them in my pocket." The care worker then proceeded to take out a denture pot and gave the person their dentures in front of two other people who were sitting at the dining room table.
- One person was given a clothing protector at lunchtime. They fell asleep at the dining table and were still wearing the clothing protector at 14:10 hours. Care workers made no attempt to wake them and move them to a more comfortable chair or remove the clothing protector.
- People were not always supported to look their best. For example, one person shaved themselves but did not always manage to finish. Their relative said staff did not pick this up and they were left looking 'half shaved.'
- A member of staff told us they did not think there was always enough care taken in making sure people looked well presented. For example, the removal women's facial hair.
- Staff did not always engage with people or respond to them in a way which reduced their anxiety.
- People's toiletries were being stored in the top of their wardrobes instead of in the en-suite bathrooms. A relative told us this had happened recently and did not know the reason why as they had been previously been readily available.

This demonstrated a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
- Care plans contained very limited information about people's cultural and religious needs and how these would be met by the service.
- There was very little or no evidence of people and/or their relatives being involved in the development of their care plans.

This demonstrated a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us staff were kind and caring, their comments included, "Yes, they are lovely," "Yes, they are kind" and "Yes, they are unbelievable. The night staff are fantastic."

● People were supported to maintain relationships with friends and relatives. People told us, "Yes, they [relatives] just arrive, and I can see them where I want," "Yes, [relatives] can visit whenever they want to come" and "My family come whenever they want."

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Care records and practices did not promote person-centred care. It was not always clear who had been consulted or involved in decisions about people's care.
- People's changing needs were not always responded to appropriately.
- People's personal and oral hygiene needs were not always being met.
- Care plans did not give staff enough detail to provide person centred care. For example, one care plan stated the person should be kept occupied, however, there was no further detail of what care workers should do.
- Some end of life care plans were in place, however, these were generic and were not person centred. Some very basic details were also missing, for example, if people wished to be buried or cremated. This meant we could not be assured people would receive appropriate end of life care.

This demonstrated a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider had not addressed the AIS. The manager was aware this needed to be addressed.

Improving care quality in response to complaints or concerns

- People and relatives told us they would feel able to complain, however, we found concerns and complaints people had made were not always being documented or responded to. One person told us, "I complained when some hearing aids and glasses went missing. It wasn't really resolved I'm not sure it was pursued or recorded." We saw complaints had been recorded in people's care records which had not been addressed.

This demonstrated a breach of regulation 16 (receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them.

● A number of activities were advertised both on notice boards and in a monthly bulletin. They included church services, visiting entertainers, competitions, films, Halloween activities and meetings for relatives and residents.

● The activities coordinator knew about people's interests and provided group and individual activities. People who used the service said, "There is a lot on offer. I know what's on, but I prefer my radio and computer," "The staff tell me what is happening, and I always go," "I do all sorts. I get to meet others; we went on the Worth valley railway recently. The staff come to collect me" and "I don't go but I know that I can."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was not well-led. The provider failed to ensure people received high quality care to achieve positive outcomes.
- Shortfalls found at this inspection had not been identified by the provider or manager.
- The registered manager left the service in July 2019. The deputy manager had been acting as the manager until a new manager had been appointed in September 2019. The new manager was in the process of registering with CQC.
- The manager was new, and it was too soon for people to have a view of their effectiveness. One relative told us, "In general there is no communication, consistency or leadership in the home. I hope [Name of manager] can turn it around."
- The shifts were disorganised and lacked leadership, which impacted on the care provided to people. There were no systems in place to ensure care tasks had been completed and monitoring forms filled in. One member of staff told us,"You don't know where you will be working or who you will be working with." Staff said this was stressful for them.
- Audits of weights, accidents/incidents and care plans were requested, none were available. The manager agreed there were no effective systems in place to monitor the quality of care at the service.
- An audit had been completed by an external consultant in May 2019 which had assessed the service against CQC's key lines of enquiry. This report identified issues which needed 'priority input.' For example, risk management, medicines management, consent to care and treatment and care plans. Additional issues which required 'further input' included, staff recruitment, mattress checks, and lessons learnt. Given the failures we have found during this inspection there is no evidence to show any action was taken to meet the recommendations made by the consultant.
- There was no evidence to show any learning from accidents, incidents or complaints. No best practice guidance was being used. This is evident in the decline of the service from a CQC rating of good to inadequate.
- Staff were not adequately supervised, and staff turnover had been high. A relative told us, "Staff turnover is still high, but the few loyal staff are very good. Agency staff has been a big problem."
- Care was not person-centred and the outcomes for some people were poor.

This demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some staff told us they did not feel listened to. Staff surveys had been sent out in July 2019, 98 had been sent out but only seven had been returned. The surveys had been analysed by the pervious manager. This analysis did not reflect the fact some staff were very dissatisfied with the management of the home.

● One person told us, "I do believe that some of that staff need to be listened to a little bit more. I think then they'd feel as though they're part of the organisation and not pushed away."

● Residents and Relatives meetings were held. People using the service said, "I've had questionnaires, I don't know if there are meetings" and "I've been to residents' meetings." Visitors told us, "There are relatives' meetings. We have met recently with the new manager and the owner. They acknowledged there was an issue with staffing and they need to get more permanent staff" and "I've never been to a relatives meeting. You only know about them if you pick a bulletin up."

Working in partnership with others

● The provider and manager had put an action plan in place to show how they were going to improve the service and were working with the local authority and CCG on this action plan.

● The provider was committed to continued investment into the service and providing any resource needed to make improvements